DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
HEALTH CARE FINANCING ADMINISTRATION
BALTIMORE, MARYLAND 21235

REFER TO:
IHI-411

November 1977

PART A INTERMEDIARY LETTER NO. 77-39
PART B INTERMEDIARY LETTER NO. 77-41

SUBJECT: Health Care Legislation: Enactment of Public Law 95-142, Medicare-Medicaid Anti-Fraud and Abuse Amendments

On October 25, 1977, the President signed Public Law 95-142, the "Medicare-Medicaid Anti-Fraud and Abuse Amendments". This new law is intended to strengthen the Government's capability to detect, prosecute, and punish fraudulent activities in Federal health care programs and to make other technical improvements.

The provisions of P.L. 95-142 are focused on four major areas: strengthened program penalty sanctions, increased disclosure of information, improvements in the PSRO program, and administrative and other changes in the Medicare and Medicaid programs.

The enclosure summarizes those provisions of the new law which directly impact upon the intermediaries, carriers, and providers of services. Reference to the specific section of P.L. 95-142 have been provided next to each subject heading.

We especially wish to call your attention to the Intermediary Assignments summation contained in section D of the enclosure. This material addresses amendments contained in section 14 (which modifies section 1816 and in particular new subsection F of section 1816) of the Social Security Act and will require the Secretary to formulate standards and criteria to determine whether the Secretary should enter into, renew, or terminate agreements with intermediaries. This revision authorizes the Secretary to assign and reassign providers to intermediaries where he determines that this will result in more efficient and effective administration of the program. The Secretary will develop criteria and standards for the assignment and reassignment of providers, as well as procedures for appeals and judicial review of these assignments.

The standards and criteria which the Secretary is required to develop under the amendments in section 14, must be promulgated by, and would be applicable to, agreements entered into, renewed or terminated on and after October 1, 1978. Current contracts will not be affected by the amendments.

Until new guidelines are issued, all current rules and instructions will remain in effect. You will be kept advised and afforded an opportunity for prior consultations as rules and instructions implementing these provisions are developed.

Thomas M. Tierney
Director
Medicare Bureau

Enclosure

Public Laws: 94th & 95th Congress / 1st & 2nd Session /
Medicare-Medicaid Fraud & abuse file

A. STRENGTHENED PROGRAM PENALTY SANCTIONS

Increased Penalties for Fraud — Section 4

The penalties for fraudulent acts under Medicare and Medicaid are upgraded from misdemeanors to felonies, punishable by a maximum fine of $25,000, up to five years imprisonment, or both. The charging or accepting of "contributions" as a condition for a Medicaid patient's admission or continued stay in a facility is also classified as a felony. In addition, physicians who agree to accept Medicare assignments and then repeatedly charge beneficiaries more than applicable cost-sharing amounts are guilty of misdemeansors, punishable by a maximum fine of $2,000, up to six months imprisonment, or both.

Suspension of Convicted Practitioners — Section 7

The Secretary is required to suspend from participation under Medicare (and direct the single State agency to suspend under Medicaid) a practitioner who has been convicted of a program-related criminal offense. In cases of suspension the Secretary will promptly notify the appropriate State or local licensing agency. The Secretary could permit a State to waive a practitioner's suspension from Medicaid participation if so requested. Effective date is January 1, 1978.

B. IMPROVEMENTS IN THE PSRO PROGRAM

Conditional PSRO Review — Section 5

The trial period for a conditional PSRO will be extended to up to 48 months (with another 24 months permitted, if the Secretary determines the PSRO is unable to perform satisfactorily for reasons beyond its control). During this period the PSRO review will apply to institutional services (including ancillary services) and any other services that the Secretary may require.

Restrictions on Reviewing Physician — Section 5

The prohibition against a PSRO physician's review of services in which he has an interest is modified to apply only to those services for which he is directly responsible, or which are furnished in a facility in which he or a family member has a significant financial interest.

CMS Library
C2-07-13
7500 Security Blvd.
Baltimore, Maryland 21244

Review of Ambulatory Care Services Section 5

The Secretary is required to give priority to a request from a PSRO (including a conditional PSRO) to undertake review of services furnished in shared health facilities. Also, within two years after it becomes fully operational a PSRO will be required to review ambulatory care services if found capable of performing such review. The Secretary could permit a PSRO to undertake such review earlier, if it so requested.

Termination of Other Review Requirements Section 5

The new law clarifies that all duplicative review activities otherwise authorized under existing law would stop when the Secretary finds a PSRO (including a conditional PSRO) competent to perform review responsibilities and that the PSRO's determinations of Medical necessity and appropriateness will be conclusive for purposes of program payment.

Annual Report Section 5

The law requires the Secretary to submit to the Congress by April 1 of each year (beginning in 1978) a detailed report on the administration impact, and cost of the PSRO program, and remove the requirement for an annual report from the National PSR Council.

Payment for Institutional Care Beyond Date Determined Medically Necessary Section 22

The law modifies the present law provision whereby Medicare hospital and skilled nursing facility patients who are determined to need no further care in the institution are allowed an additional 3 days of benefits to give them time to arrange for their post-discharge care. The 3-day period is reduced to 1 day where a PSRO is undertaking the review; however, the PSRO could authorize up to 2 additional days on a case-by-case basis. Federal matching funds for such stays under title XIX would be subject to the same conditions.

PSRO-Medicaid State Agency Relations Section 5

The law includes several provisions, which are designed to clarify the roles of the PSRO and the State Medicaid Agency in the review of Medicaid services. In the preparation and modifications of its formal plan, a PSRO is required to consult with the State agency and to submit the plan for comment by the Governor of the State. Before its determinations become conclusive for Medicaid purposes a PSRO is required to enter into a Memorandum of Understanding with the State Agency. The State Agency will monitor the performance of a PSRO, and the PSRO's review could be suspended if the monitoring established faulty performance. ICF review is the State's responsibility except where the State agency is not performing such review effectively, or it requests the PSRO to assume the review.

Abolition of Program Review Team Section 13

The law repeals the program review team provision of the Medicare law. The functions formerly performed by such teams with respect to the quality and utilization of services will be performed by PSROs.

C. INCREASED DISCLOSURE OF INFORMATION

Disclosure of Ownership and Related Information Section 3

The law will require providers, health maintenance organizations, and suppliers (other than individual practitioners) under Medicare, Medicaid and the Maternal and Child Health Program, and entities providing health related services under title XX, to disclose ownership information (including information relating to subcontractors) as a condition of program participation. Provider entities will be required to disclose upon request, information concerning any significant business transactions with any subcontractor or wholly-owned supplier. These disclosure requirements will also apply to Medicare intermediaries and carriers and Medicaid fiscal agents. (Emphasis added.)

Disclosure by Providers of Owners Convicted of Fraud Section 8

The law will require all institutions, organizations, or agencies providing services under Medicare, Medicaid, or title XX State social service grant programs to disclose to the Secretary or the appropriate State agency the name of any owners who have been convicted of fraud against any of these programs. The Secretary or the State agency may refuse to enter into or renew any agreement or contract to provide services under these programs is there is a direct or indirect ownership or a control interest of at least 5 percent by such a convicted person. This provision will also apply to officers, directors, agents, and managing employees.

Disclosure by Providers of the Hiring of Former Intermediary Employees Section 15

A provider of services under the Medicare program will be required to notify the Secretary promptly if it employs an individual who during the preceding year was employed in a managerial, accounting, auditing, or similar capacity by the intermediary or carrier serving the provider. (Emphasis added.)

Issuance of Subpoenas by Comptroller General Section 6

The law authorizes the Comptroller General of the United States to sign and issue subpoenas in order to facilitate review of any Social Security Act program. If the individual refused to obey a subpoena, the Comptroller General could seek a court order through the Department of Justice requiring compliance.

D. MEDICARE-MEDICAID ADMINISTRATIVE AND OTHER CHANGES

Intermediary Assignments Section 14

Section 1816 is modified and the new law precludes the Secretary from entering into or renewing contracts with intermediaries failing to meet predetermined performance standards and criteria. The Secretary's prerogatives, with respect to contract renewals, will not otherwise be affected.

The law authorizes the Secretary to assign and re-assign Medicare providers to intermediaries and to use regional and national intermediaries for a single class of providers. Before making any assignments or reassignments, the Secretary will have to develop and apply standards and criteria of intermediary performance. Also, the Secretary will be required to develop and apply standards with respect to efficient and effective administration. Under such standards and criteria, providers may not be removed from an intermediary solely because that intermediary operates in a single State.

Determinations by the Secretary on provider assignments and reassignments will be subject to hearing and, when applicable, judicial review.

Payment for Durable Medicare Equipment (DME) Section 16

The law directs the Secretary to require the purchase of DME under the Medicare program if he finds that purchase will be less costly or more practical than extended rental payments and will not impose financial hardship on the beneficiary. Payment could be made for such equipment on a lump-sum basis (or on the basis of lease-purchase arrangements, where available). Existing authority is retained for the Secretary to waive the 20 percent coinsurance for the purchase of used DME where the purchase price is at least 25 percent less than the reasonable charge for comparable new equipment. The Secretary will also be required to encourage suppliers to make equipment available on a lease-purchase basis. Effective date is October 1, 1977.

Protection of Patient Funds Section 21

The law requires as a condition of participation in Medicare and Medicaid that a skilled nursing or intermediate care facility must establish and maintain a system to assure the proper accounting of the personal funds of patients. This system must provide for a separate account for each patient with a complete accounting of income and expenditures. Similar requirements are now in the skilled nursing and intermediate care facility regulations.

CMS Library
C2-07-13
7500 Security Blvd.
Baltimore, Maryland 21244

Payment for Certain Services Provided in Veterans Administration Hospitals Section 23

The law authorizes, under certain circumstances, Medicare reimbursement to a Veterans Administration hospital for care provided to a non-veteran Medicare beneficiary where the care was provided on the mistaken (but good faith) assumption that the beneficiary was an eligible veteran. The provision would be applicable to care furnished on or after July 1, 1974.

Prohibition of Factoring Arrangements Section 2

P.L. 95-142 clarifies existing law to preclude the use of a power of attorney as a device to circumvent present prohibitions against the use of "factoring" arrangements in connection with the payment of claims under Medicare and Medicaid. These arrangements permit physicians and suppliers to sell their accounts receivable to bill collection agencies in order to receive more immediate payment (although at discount) for their services. This practice has frequently fostered program abuses. To reduce the undue delays in program payment which have led to factoring arrangements, the law requires State Medicaid plans to pay 90 percent of "clean" claims (i.e., claims which do not require additional evidence) within 30 days, and 99 percent within 90 days.

Uniform Reporting System Section 19

The Secretary is required to establish a uniform reporting system, by type of provider for Medicare and Medicaid for reporting of such items as cost of operations, volume of services, rates, capital assets, and bill data to allow for better comparison and review of provider performance. In addition, hospitals will be required to use a uniform chart of accounts, definitions, principles, and statistics of such reports.

Studies Sections 12 and 18

The law authorizes two studies: (1) a comprehensive study of Medicare's claims processing operations, to be conducted by the Comptroller General of the United States, and (2) an evaluation of all home health services provided under Medicare, Medicaid, and the title XX grant programs, with a report to be submitted by the Secretary to the Congress within one year after enactment. The law also authorizes the Secretary to develop or demonstrate improved methods for investigating or prosecuting program fraud.

CMS LIBRARY
3 8095 00007200 5